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ABSTRACT

Health care will continue to occupy a prominent place in state legislative deliberations, as indicated by the National Conference of State Legislatures' 1987 State Issues Survey. The survey addressed state actions in these health issue areas: (1) health care for the medically indigent; (2) medical malpractice; (3) certificate of need and health planning; (4) long-term care and Alzheimer's disease; (5) Medicaid and medical assistance programs; (6) professional licensure; (7) organ transplantation and donation; (8) Acquired Immune Deficiency Syndrome; (9) health insurance; (10) state employee health plans; and (11) hospitals. The survey form was sent to legislators in all 50 states with 39 states responding. For each of the 11 issues, respondents were given a number of possible actions state legislatures might consider. They were also asked to describe additional actions not included in the list. (Results are discussed for each of the 11 topics. Tables with responses from each state are provided for each topic.) (ABL)

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MAJOR HEALTH ISSUES FOR STATES: 1987

By
David Landes

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INTRODUCTION

Health care will continue to occupy a prominent place in state legislative deliberations, as indicated by NCSL's 1987 State Issues Survey. The survey addressed state actions in a number of health issue areas:

- health care for the medically indigent
- medical malpractice
- certificate of need and health planning
- long-term care and Alzheimer's disease
- Medicaid and medical assistance programs
- professional licensure
- organ transplantation and donation
- AIDS
- health insurance
- state employee health plans
- hospitals

The survey form was sent to legislators and legislative staff in all 50 states in late 1986. Only 11 states did not respond to the survey: Alaska, Georgia, Idaho, Kentucky, Massachusetts, Michigan, Missouri, New Mexico, Pennsylvania, South Carolina, and Washington. For each of the 11 issues, respondents were given a number of possible actions state legislatures might consider. They were also asked to describe additional actions not included in the list.

Survey results are described in the text. State-by-state tables follow the text.

HEALTH CARE FOR THE MEDICALLY INDIGENT

Funding for health expenses for those who cannot afford to pay themselves has been an important issue in past years and will continue to be in 1987. The medically indigent are the group of people who are not poor enough to qualify for Medicaid or medical assistance but who do not have insurance or personal assets sufficient to pay medical bills. Studies have shown that many of these people are working but uninsured for medical care. Much of the care they receive is for accidents, common medical problems, or childbirth. In the past, hospitals and other health care providers subsidized the cost of care for this population by charging higher prices to other payers. However, health care cost containment pressures from both public and private third-party payers have made it more difficult for providers to continue this practice. As a result, providers have limited the amount of charity care they will provide, placing larger burdens on public facilities and on those providers unwilling to limit charity care. Both providers and advocates for the poor have actively sought legislative action in this area.

Three possible options for addressing the medical indigency problem were mentioned frequently by respondents (Table 1):

- Expand eligibility for Medicaid or medical assistance (19 states)

  The Medicaid program is the primary vehicle for paying the medical care for the poor, and extension of this program to the medically indigent is a logical proposal. Recent changes in federal law allow states to extend Medicaid coverage to certain pregnant women, children, and elderly persons. An additional advantage of Medicaid expansion is the possible availability of federal matching funds, which may reduce the states' funding contribution.

- Provide funding for prenatal care (17 states)

  Prenatal care is one of the health care services most often needed by the medically indigent. Prenatal care is often considered especially important, because small investments of funds can prevent massive lifetime expenses due to birth defects and other birth-related problems.

- Establish risk pools for uninsurable persons (14 states)

  Some persons cannot get health insurance, because they are in high-risk medical or occupational categories and are not part of a large insurance-purchasing group. Some states have established special insurance pools for these individuals, offering low premiums subsidized by a tax on insurers or by state general funds.

Other options frequently identified by respondents were:

- Create a medically indigent fund, paid for by assessments on hospitals, third-party payers, employers, long-term care facilities, or counties (12 states);

- Increase access to emergency medical care for the indigent (12 states);

- Redistribute uncompensated care costs more equitably among hospitals (11 states);

- Establish pharmaceutical assistance programs for the elderly (10 states).

MEDICAL MALPRACTICE

In 1986 more than 30 states passed legislation related to medical malpractice. Early state indicators predict that medical malpractice will continue to be an important issue in 1987. Insurers claim that skyrocketing claims, settlements, and court awards threaten their financial solvency, necessitating large premium increases or complete withdrawal from the market. Providers, faced with premium hikes or insurance cancellation, have urged legislatures to limit the financial pressure on insurers. On the other hand, trial lawyers and public advocates have accused insurers of creating a phoney crisis as a way of getting legislatures to limit the legitimate claims of policyholders.

A number of possible alternatives were identified by survey respondents (Table 2):

- Limit insurers' financial burden (16 states)

  These limits include caps on total awards or on awards for specific types of damages and payment of awards over time, rather than in a lump sum. Another common change would be the elimination of the collateral source rule, which makes all other defendants liable for payment of damage awards against those who cannot afford to pay.

- Limit attorneys' fees (14 states)

  Limits on attorneys' fees are proposed as a way of reducing attorneys' incentives to file malpractice suits, because most malpractice attorneys' fees are based on a percentage of the damage awards.

- Reduce the statute of limitations (10 states)

  Reducing the period of time within which malpractice suits must be filed is seen as a way of reducing the number of suits filed.

- Institute medical malpractice insurance data collection (10 states)

  Many policymakers have commented on the lack of reliable data on which to evaluate the insurance industry's claims of financial losses. Reporting of claims information to state regulators is seen as one way of assuring that such information will be available for future legislative consideration.

Other possible legislative options identified by respondents were:

- Improve discipline of negligent providers (9 states);
- Encourage claims resolution without trial through such reforms as arbitration or pretrial screening panels (7 states);
- Assist physicians in obtaining medical malpractice insurance coverage (7 states).

CERTIFICATE OF NEED (CON) AND HEALTH PLANNING

Abolition of federal health planning requirements and withdrawal of federal funds will motivate states to reexamine the scope of health planning and certificate of need programs. Aimed at reducing health care costs, these programs attempt to control the number and type of health care facilities through state-mandated review and approval procedures. They have been criticized as ineffective, inconsistent, and inappropriate in today's climate of deregulation.

The possible actions described by survey respondents indicate a divergence of opinion. Some states will consider both weakening and strengthening these programs. Options identified include (Table 3):

- Reduce the powers of CON programs (17 states)

  The nationwide trend has been to deregulate certain types of facilities and providers such as ambulatory surgical centers and home health agencies. Also, the capital expenditure "thresholds," which determine projects subject to state review, have been increased, reducing the number of projects reviewed.

- Abolish of the CON program (10 states)

  Outright abolition of CON would remove most controls on the number of health care facilities.

- Strengthen the CON program (10 states)

  Actions to strengthen the CON program are the opposite of those described above.

In addition to these actions, four states will consider imposing moratoriums on construction of certain types of health facilities.

LONG-TERM CARE AND ALZHEIMER'S DISEASE

Long-term care has figured prominently in legislative deliberations, because of the growth in the elderly population and the large portion of the Medicaid budget devoted to long-term care. Recent long-term care issues have included: improvements in the nursing home system, increasing the efficiency and effectiveness of the Medicaid system, and developing a range of noninstitutional long-term care services. Alzheimer's Disease, which causes progressive mental and physical deterioration in its victims, has had high visibility in the media.

The most frequently mentioned legislative options in this area were (Table 4):

- Expand Alzheimer's Disease activities (22 states)

  Possible state activities include: establishing or expanding services to Alzheimer's victims and their families, funding research into the illness, and broadening eligibility for existing services to include individuals impacted by Alzheimer's Disease.

- Regulate long-term care insurance (16 states)

  Long-term care insurance for nursing home and home health care is attracting increased interest and acceptance among the elderly. States have become interested in long-term care insurance, because widespread insurance could reduce Medicaid long-term care expenditures. State actions generally have been in the area of regulation to protect consumers or incentives to encourage purchase.

- Establish case management systems for long-term care (14 states)

  Case management means placing responsibility for coordination and approval of long-term care services for each individual in the hands of a single person. The goals are two: to eliminate the cost of duplicative or unnecessary service provision and to improve care for the individual. State actions in this area have dealt exclusively with case management for the Medicaid population, the consumers of state-financed care.

- Enhance the quality of long-term care (12 states)

  Quality of care has been a continuing concern in long-term care. Changes in licensing and facility review regulations and initiation of ombudsman programs are possible options for nursing homes. Quality can also be enhanced through reduced institutionalization and the licensing of day care services and small group homes.

Other legislative issues related to long-term care were:

- Prohibit discrimination by nursing homes against Medicaid recipients (10 states);

- Apply for a Medicaid waiver for services that will be offered as alternatives to institutionalization (10 states);

- Change Medicaid nursing home reimbursement systems (8 states).

MEDICAID AND MEDICAL ASSISTANCE PROGRAMS

The Medicaid program, providing health care to the poor, is the largest state health care program. Partially funded by federal matching funds, it covers physician, hospital, and nursing home care. The primary legislative concern has been the cost of the program, which goes back to the number of persons eligible and the scope of services covered. In some states, costs have risen at an alarming rate. A second concern has been efficient operation and management of the program.

Although program cost has been a concern, the most frequently mentioned options to be considered by legislators in 1987 all involve eligibility or service expansions. This may involve use of tax windfall funds (Table 5):

- Expand Medicaid eligibility (19 states)

  This involves making additional categories of individuals eligible for Medicaid. For example, the recently-passed 1986 Omnibus Budget Reconciliation Act allows states to extend Medicaid eligibility to certain elderly persons and single parents and children without also extending AFDC and other assistance programs. This was not possible previously. A number of states have made known their intention to use this option. Another Medicaid expansion might be to include the medically indigent.

- Expand Medicaid services (11 states)

  Possible service expansions would be pharmaceuticals and home health care.

- Reduce spousal impoverishment due to asset "spend down" (11 states)

  Under existing law, some or all of a married couple's assets must be used to pay for long-term care before Medicaid benefits can begin. For couples with only one spouse institutionalized, few assets or income may remain for support of the noninstitutionalized spouse, forcing them onto the assistance rolls. Many states are moving to limit the spend down of assets, enabling the spouse to maintain financial independence as long as possible.

Other proposals to be considered in 1987 include:

- Establish programs to enroll recipients in prepaid, capitated health plans, e.g., HMOs and primary-care case management (9 states);

- Establish mandatory utilization controls for non-emergency services such as preadmission screening, second surgical opinions, and continued stay review (9 states).

PROFESSIONAL LICENSURE

Licensure of health occupations is a continuing issue for state legislators. Occupational groups seeking the recognition and exclusivity that state licensure brings are frequently the subjects of legislative debate. Similarly, occupational groups seeking to expand their scope of practice engage in adversarial battles with other groups whose exclusive perogatives may be threatened by their expansion. Aside from acting as referee in these continuing struggles, state legislatures may need to exercise oversight over the activities of state licensed occupational groups and the agencies that license them.

The most frequently mentioned legislative actions for 1987 relate to health professions regulation (Table 6):

- Credential or license additional health care personnel (22 states)

- Revise or strengthen health profession discipline regulations (13 states)

  A renewed concern about the problem of impaired physicians and other health care providers has been a byproduct of the medical malpractice insurance crisis.

- Extend prescription writing priviledges to additional health care professions (9 states)

  The continuing attempts by pharmacists and others to break an almost exclusive right of physicians to prescribe medications is a specific example of competition betweem occupations. In 1986 Florida became the first state to allow pharmacists to prescribe medications under certain circumstances. Other states can be expected to consider similar legislation.

ORGAN TRANSPLANTATION AND DONATION

Scientific advances have moved many types of organ transplantation from experimental status into the health care system, raising numerous ethical and financial problems for the states. Two possible state actions were cited most frequently in the survey (Table 7):

- Pass organ donor request laws requiring hospitals to request next-of-kin to consent to organ donations (8 states)

  "Required request" laws have become popular as a way of increasing the supply of organs available for transplantation.

- Expand Medicaid funds available to pay for transplants (7 states)

  State Medicaid programs are under a mandate to rationalize criteria for determining transplants to be covered, and specific circumstances of eligibility. This rationalization process may well

lead to coverage of more types of transplants and of greater numbers of transplants. Also, Medicaid programs have been slower to approve transplant coverage than private sector health plans, and expanded coverage may be the result of "catching up."

AIDS

The spread of AIDS has presented states with many ethical, public health, and financial dilemmas. The presence of AIDS victims in everyday work and social settings have prompted calls for restriction of activities. Increased knowledge about the means of transmission of the disease has prompted legislative action to create screening programs and procedures to halt the spread of the disease.

The most frequently mentioned state actions to be considered in 1987 were (Table 8):

- Expand state public health departments' authority by allowing them access to antibody test results, quarantine certain infected individuals, or track AIDS in a manner similar to that used for other venereal diseases (14 states)

  State health departments bear primary responsibility for public efforts to combat AIDS. While many departments already have the authority to take certain measures to protect the public health, the concern about AIDS has lead to a number of specific legislative proposals aimed at making these procedures explicitly available for use against AIDS. These measures have been criticized as unnecessary and unduly discriminatory.

- Specify procedures for prisons (11 states)

  Preventing the spread of AIDS among prison populations is the object of this type of legislation.

- Specify procedures for schools (11 states)

  Increasing numbers of children and adolescents are diagnosed with AIDS. These measures provide criteria for making decisions about the circumstances under which students with AIDS will be allowed to attend school.

- Fund services to AIDS victims, including public education, research, counseling, and testing (10 states)

  An important aspect of the AIDS problem is identification and counseling for victims. Knowledge and education are considered critical in helping victims deal with the effects of the disease and in preventing its spread.

- Specify procedures for blood banks (10 states)

  Blood and blood products are an important mode of AIDS transmission and have been the object of many attempts to reduce the spread of the disease.

- Prohibit access to HTLV-III (AIDS antibody) test results by non-government parties who may discriminate against those who test positive, such as insurance companies, landlords, and employers (9 states)

  Public fear of the spread of AIDS has raised the possibility of discrimination against AIDS victims, even where there is no objective reason to believe transmission of the disease could occur. These proposals attempt to prohibit such discrimination.

HEALTH INSURANCE

The most frequently mentioned health insurance issues to be discussed by state legislatures were (Table 9):

- Establish or amend HMO regulations (17 states)

- Mandate new insurance benefits (14 states)

  Amidst increasing controversy, many states have enacted legislation mandating that health insurers include certain specified benefits in all policies. Proponents of these laws claim that they guarantee access to necessary services that consumers might otherwise forgo. Critics argue that such mandates increase the cost of health insurance for everyone and drive employers toward self-insurance, putting them beyond the scope of all state insurance regulation. Some states have acted to adopt guidelines for determining the costs and benefits of all proposed insurance mandates prior to legislative consideration.

- Establish or amend preferred provider organization (PPO) regulations (11 states)

  Preferred provider organizations are networks of health care providers that contract to provide health care services on a prepaid capitated basis. Some states still do not legally sanction the formation of PPOs.

STATE EMPLOYEE HEALTH PLANS

Only two proposals received significant mention in this category (Table 10):

- Expand health benefits (7 states)
- Implement cost controls, such as offering a PPO or HMO option, or implement a second surgical opinion requirement (4 states)

HOSPITALS

States are involved with hospitals in many ways. States have total responsibility for the regulation of hospitals through the licensing process. As payers for health care through Medicaid and medically indigent programs, they can influence hospitals' profitability. Finally, state health care cost containment programs, such as rate setting or data dissemination programs, influence market conditions under which hospitals operate.

Two proposals were mentioned most often by survey respondents (Table 11):

- Establish or expand a data collection program (12 states)

  Data collection programs are intended to promote reduced price competition among providers by collecting and publically disseminating price data.

- Establish a state medical utilization or peer review organization to monitor use of Medicaid-reimbursed care (3 states)

TABLE 1: HEALTH CARE FOR THE MEDICALLY INDIGENT

States*	Expand Medicaid Eligibility	Fund Prenatal Care	Catastrophic Risk Pools
ALABAMA			
ARIZONA			
ARKANSAS			•
CALIFORNIA		•	•
COLORADO			
CONNECTICUT	•		
DELAWARE	•	•	•
FLORIDA	•	•	
HAWAII		•	
ILLINOIS	•	•	•
INDIANA			•
IOWA			
KANSAS	•	•	•
LOUISIANA		•	
MAINE			
MARYLAND	•		•
MINNESOTA	•	•	
MISSISSIPPI			
MONTANA			
NEBRASKA		•	
NEVADA	•		•
NEW HAMPSHIRE			
NEW JERSEY	•	•	
NEW YORK	•	•	•
NORTH CAROLINA	•		•
NORTH DAKOTA			
OHIO	•	•	•
OKLAHOMA	•	•	•
OREGON	•	•	
RHODE ISLAND			
SOUTH DAKOTA			
TENNESSEE	•		
TEXAS			
UTAH	•	•	•
VERMONT			
VIRGINIA	•	•	
WEST VIRGINIA		•	
WISCONSIN	•		
WYOMING	•		•

* States not responding to the survey are not included in the table.

TABLE 2: MEDICAL MALPRACTICE

States*	Limits on Recoveries	Limits on Attorney's Fees	Change Statute of Limitations	Malpractice Insurance Data
ALABAMA	•	•	•	
ARIZONA	•	•	•	
ARKANSAS	•			
CALIFORNIA	•	•	•	•
COLORADO				
CONNECTICUT				
DELAWARE	•	•		•
FLORIDA				
HAWAII				•
ILLINOIS				
INDIANA				
IOWA				
KANSAS				
LOUISIANA	•	•		
MAINE	•	•	•	•
MARYLAND	•	•	•	•
MINNESOTA				
MISSISSIPPI				
MONTANA				
NEBRASKA	•	•		
NEVADA	•	•		
NEW HAMPSHIRE	•	•		•
NEW JERSEY	•	•	•	•
NEW YORK				•
NORTH CAROLINA				
NORTH DAKOTA				
OHIO			•	
OKLAHOMA				
OREGON	•	•	•	•
RHODE ISLAND				
SOUTH DAKOTA				
TENNESSEE	•	•	•	•
TEXAS				
UTAH				
VERMONT				
VIRGINIA	•		•	
WEST VIRGINIA				
WISCONSIN				
WYOMING	•	•		

* States not responding to the survey are not included in the table.

TABLE 3: CERTIFICATE OF NEED AND HEALTH PLANNING

States*	Reduce CON Powers	Abolish CON	Strengthen CON
ALABAMA			•
ARIZONA			
ARKANSAS		•	
CALIFORNIA			
COLORADO		•	
CONNECTICUT			
DELAWARE			
FLORIDA	•	•	
HAWAII	•		
ILLINOIS		•	•
INDIANA	•	•	•
IOWA			
KANSAS			
LOUISIANA	•		•
MAINE	•		
MARYLAND			•
MINNESOTA			
MISSISSIPPI			
MONTANA			
NEBRASKA	•		
NEVADA	•		
NEW HAMPSHIRE	•		
NEW JERSEY	•		
NEW YORK			•
NORTH CAROLINA	•		
NORTH DAKOTA			
OHIO	•	•	
OKLAHOMA			
OREGON	•	•	•
RHODE ISLAND			•
SOUTH DAKOTA	•	•	•
TENNESSEE			
TEXAS			
UTAH			•
VERMONT			
VIRGINIA	•	•	
WEST VIRGINIA	•		
WISCONSIN	•	•	
WYOMING	•		

* States not responding to the survey are not included in the table.

TABLE 4: LONG-TERM CARE AND ALZHEIMER'S DISEASE

States*	Services for Alzheimer's Disease	Long-Term Care Insurance	Implement Case Management	Enhance Quality of Care
ALABAMA	•			
ARIZONA				
ARKANSAS	•		•	•
CALIFORNIA	•	•	•	•
COLORADO				•
CONNECTICUT	•			
DELAWARE	•	•		•
FLORIDA	•	•	•	
HAWAII	•		•	
ILLINOIS		•		•
INDIANA	•	•	•	
IOWA	•			
KANSAS	•	•	•	
LOUISIANA		•	•	
MAINE				
MARYLAND	•			
MINNESOTA	•			
MISSISSIPPI				
MONTANA	•	•		
NEBRASKA		•	•	
NEVADA		•	•	•
NEW HAMPSHIRE	•			
NEW JERSEY	•		•	•
NEW YORK	•	•	•	•
NORTH CAROLINA		•		
NORTH DAKOTA	•			
OHIO				
OKLAHOMA		•	•	•
OREGON	•	•		•
RHODE ISLAND	•		•	
SOUTH DAKOTA	•			
TENNESSEE	•	•	•	•
TEXAS				
UTAH				
VERMONT				
VIRGINIA	•			
WEST VIRGINIA				•
WISCONSIN		•		
WYOMING				

* States not responding to the survey are not included in the table.

TABLE 5: MEDICAID AND MEDICAL ASSISTANCE PROGRAMS

States*	Expand Eligibility	Expand Services	Reduce Spousal Impoverishment
ALABAMA		•	
ARIZONA			
ARKANSAS		•	
CALIFORNIA	•	•	•
COLORADO			
CONNECTICUT	•		
DELAWARE	•	•	
FLORIDA	•		
HAWAII			
ILLINOIS	•	•	
INDIANA			•
IOWA			
KANSAS			•
LOUISIANA			
MAINE			
MARYLAND	•	•	
MINNESOTA	•		
MISSISSIPPI			
MONTANA			
NEBRASKA			•
NEVADA	•		
NEW HAMPSHIRE			
NEW JERSEY			
NEW YORK	•	•	•
NORTH CAROLINA	•		
NORTH DAKOTA			
OHIO	•		
OKLAHOMA	•	•	•
OREGON	•		•
RHODE ISLAND	•		•
SOUTH DAKOTA		•	
TENNESSEE			•
TEXAS			
UTAH	•	•	
VERMONT	•		•
VIRGINIA	•	•	•
WEST VIRGINIA			
WISCONSIN	•		
WYOMING	•		

* States not responding to the survey are not included in the table.

TABLE 6: PROFESSIONAL LICENSURE

States*	License Additional Providers	Professional Discipline Regulations	Expand Rx Privilege
ALABAMA	•		
ARIZONA	•	•	
ARKANSAS			
CALIFORNIA	•	•	•
COLORADO	•		
CONNECTICUT	•		
DELAWARE			
FLORIDA			
HAWAII			
ILLINOIS	•		
INDIANA			
IOWA			
KANSAS	•		•
LOUISIANA	•	•	•
MAINE			
MARYLAND	•		
MINNESOTA	•		
MISSISSIPPI			
MONTANA	•	•	
NEBRASKA	•	•	
NEVADA			
NEW HAMPSHIRE	•		
NEW JERSEY			
NEW YORK		•	
NORTH CAROLINA			
NORTH DAKOTA			
OHIO	•	•	•
OKLAHOMA	•		
OREGON	•	•	•
RHODE ISLAND	•	•	
SOUTH DAKOTA			
TENNESSEE			•
TEXAS			
UTAH	•	•	
VERMONT	•	•	
VIRGINIA	•	•	•
WEST VIRGINIA			
WISCONSIN	•	•	•
WYOMING	•		•

* States not responding to the survey are not included in the table.

TABLE 7: ORGAN TRANSPLANTATION AND DONATION

States*	Required Donation Request	Expand Medicaid Coverage
ALABAMA	•	
ARIZONA		
ARKANSAS		
CALIFORNIA		•
COLORADO		
CONNECTICUT		
DELAWARE		•
FLORIDA		•
HAWAII		
ILLINOIS		
INDIANA		
IOWA		
KANSAS		•
LOUISIANA	•	
MAINE		
MARYLAND	•	
MINNESOTA		
MISSISSIPPI		
MONTANA	•	
NEBRASKA	•	
NEVADA		
NEW HAMPSHIRE		
NEW JERSEY	•	
NEW YORK		
NORTH CAROLINA		
NORTH DAKOTA		
OHIO	•	
OKLAHOMA	•	•
OREGON		•
RHODE ISLAND		
SOUTH DAKOTA		
TENNESSEE		
TEXAS		
UTAH		
VERMONT		
VIRGINIA		
WEST VIRGINIA		
WISCONSIN		•
WYOMING		

* States not responding to the survey are not included in the table.

TABLE 8: AIDS

States*	Expand Health Department Authority	Prisons	Schools	Funding for Services	Blood Banks	Confidentiality of Test Results
ALABAMA		•	•		•	
ARIZONA		•	•		•	
ARKANSAS						
CALIFORNIA	•	•	•	•	•	•
COLORADO						
CONNECTICUT		•		•	•	•
DELAWARE	•	•	•		•	
FLORIDA	•	•	•	•	•	•
HAWAII	•			•		
ILLINOIS	•		•	•	•	•
INDIANA	•		•	•		
IOWA						
KANSAS	•					
LOUISIANA						
MAINE						
MARYLAND						
MINNESOTA				•		
MISSISSIPPI						
MONTANA						
NEBRASKA						
NEVADA						
NEW HAMPSHIRE						
NEW JERSEY	•	•	•			•
NEW YORK	•	•	•	•	•	•
NORTH CAROLINA						
NORTH DAKOTA						
OHIO	•			•		•
OKLAHOMA	•	•	•		•	
OREGON	•			•		•
RHODE ISLAND	•					
SOUTH DAKOTA						
TENNESSEE	•	•	•		•	
TEXAS						
UTAH						
VERMONT						•
VIRGINIA						
WEST VIRGINIA						
WISCONSIN		•				
WYOMING						

* States not responding to the survey are not included in the table.

TABLE 9: HEALTH INSURANCE

States*	HMO Regulations	Mandated Benefits	PPO Regulations
ALABAMA	•	•	•
ARIZONA	•	•	•
ARKANSAS	•	•	•
CALIFORNIA	•	•	•
COLORADO			
CONNECTICUT		•	
DELAWARE	•		•
FLORIDA		•	•
HAWAII	•		
ILLINOIS		•	
INDIANA			
IOWA			
KANSAS			
LOUISIANA	•		•
MAINE			
MARYLAND	•	•	•
MINNESOTA	•	•	
MISSISSIPPI	•		
MONTANA			
NEBRASKA			
NEVADA	•		•
NEW HAMPSHIRE			
NEW JERSEY	•		
NEW YORK	•		
NORTH CAROLINA			
NORTH DAKOTA			
OHIO	•		
OKLAHOMA	•	•	•
OREGON	•	•	
RHODE ISLAND			
SOUTH DAKOTA			
TENNESSEE	•	•	•
TEXAS			
UTAH			
VERMONT		•	
VIRGINIA			
WEST VIRGINIA			
WISCONSIN		•	
WYOMING			

* States not responding to the survey are not included in the table.

TABLE 10: STATE EMPLOYEE HEALTH PLANS

States*	Expanded Benefits	Cost Containment Procedures
ALABAMA	•	•
ARIZONA		
ARKANSAS		
CALIFORNIA	•	
COLORADO	•	
CONNECTICUT		
DELAWARE	•	•
FLORIDA	•	•
HAWAII		
ILLINOIS		
INDIANA		
IOWA		
KANSAS		
LOUISIANA		
MAINE		
MARYLAND		
MINNESOTA		
MISSISSIPPI		
MONTANA		
NEBRASKA		
NEVADA		
NEW HAMPSHIRE		
NEW JERSEY		
NEW YORK		
NORTH CAROLINA		
NORTH DAKOTA	•	•
OHIO		
OKLAHOMA	•	
OREGON		
RHODE ISLAND		
SOUTH DAKOTA		
TENNESSEE		
TEXAS		
UTAH		
VERMONT		
VIRGINIA		
WEST VIRGINIA		
WISCONSIN		
WYOMING		

* States not responding to the survey are not included in the table.

TABLE 11: HOSPITALS

States*	Data Collection	Medicaid Utilization Review
ALABAMA		•
ARIZONA		
ARKANSAS		•
CALIFORNIA	•	
COLORADO		
CONNECTICUT		
DELAWARE		
FLORIDA	•	
HAWAII	•	
ILLINOIS		
INDIANA		
IOWA		
KANSAS		
LOUISIANA	•	
MAINE		
MARYLAND		
MINNESOTA		
MISSISSIPPI		
MONTANA		
NEBRASKA	•	
NEVADA	•	
NEW HAMPSHIRE		•
NEW JERSEY	•	
NEW YORK		
NORTH CAROLINA		
NORTH DAKOTA		
OHIO	•	
OKLAHOMA	•	
OREGON	•	
RHODE ISLAND		
SOUTH DAKOTA		
TENNESSEE		
TEXAS		
UTAH		
VERMONT		
VIRGINIA	•	
WEST VIRGINIA		
WISCONSIN	•	
WYOMING		

* States not responding to the survey are not included in the table.